New Hampshire Board of Medicine

2 INDUSTRIAL PARK DRIVE, SUITE 8, CONCORD, NH 03301-8520
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.state.nh.us/medicine

TO THE APPLICANT:

This application must be completed in full for consideration of certification as a Physician Assistant in the state of New Hampshire. The following documentation is required:

1. Completion of the enclosed supervisory form with original signatures from the designating Registered Supervisory Physician/Alternate Registered Supervisory Physician.

*2. Certified proof of graduation from Physician Assistant Program as defined in Med 601.03.

*3. Certification of scores received directly from National Commission on Certification of Physician Assistants (NCCPA).

4. Two letters of reference from physicians who can attest to your performance as a Physician Assistant. These letters must be on proper letterhead, submitted as originals. References may be submitted by the applicant or by the physician providing the reference.

5. A personal interview with a member of the Committee is required. (See attached list of Committee Members)

6. State Clearance (form attached) from every state in which you have ever held a license.

***2 and 3 above may be obtained through the Federation of State Medical Boards' Credentialing Verification Service (FCVS). FCVS provides primary source verification of your "core" medical credentials. The base fee for the FCVS profile is $145.00. The application for FCVS is available via the Federation's website at** www.fsmb.org **or you may contact FCVS at 1-800-ASK-FCVS.**

A copy of the PA Practice Act (RSA 328-D) and the Administrative Rules are enclosed for your information and file.

Any change in RSP/ARSP after licensure will require filing of a change in supervisor form, obtained through this office.

Enclosures.

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APPLICATION FOR CERTIFICATION AS A PHYSICIAN ASSISTANT

FEE IS $100.00 -- Make check payable to: Treasurer, State of New Hampshire

PERSONAL INFORMATION

NAME:_____
(FIRST) (MIDDLE) (LAST) (MAIDEN)

ADDRESS:_____
(STREET, CITY, STATE, ZIP CODE) (TELEPHONE #)

BIRTHDATE:_____PLACE OF BIRTH:_____

SOCIAL SECURITY NUMBER:_____

VERIFICATION OF P.A. EDUCATION

NAME OF COLLEGE/PROGRAM:_____

_____
(ADDRESS OF COLLEGE/PROGRAM) (DATE OF GRADUATION)

**ENCLOSE A CERTIFIED COPY OF GRADUATION CERTIFICATE/DIPLOMA
OR HAVE LETTER COME DIRECTLY FROM SCHOOL VERIFYING GRADUATION **OR** i**f you are using FCVS for verification, please start that process immediately.**
PLEASE MAKE ARRANGEMENTS TO HAVE NCCPA SCORES SENT DIRECTLY FROM NCCPA TO THIS OFFICE **OR** i**f you are using FCVS for verification, please start that process immediately.**

EMPLOYMENT INFORMATION

PROPOSED EMPLOYER:_____

ADDRESS:_____

TELEPHONE NUMBER:_____

ANTICIPATED DATE OF EMPLOYMENT:_____

STATES OTHER LICENSES/CERTIFICATION

Please list all states where **you hold or have ever held** licensure/certification and the number. **Please send the enclosed clearance to each state for official verification.**

STATE	**LICENSE/CERTIFICATION #**
_____	_____
_____	_____
_____	_____

REFERENCES

Please have two letters of reference submitted from physicians who have served in an advisory capacity to the applicant. Letters must be on letterhead, submitted as originals. References may be submitted by the applicant or by the physician providing the reference.

PERSONAL INTERVIEW

Please make arrangements to have a personal interview with one member of the Committee (list attached).

	YES	NO
1. Have you ever, for any reason, been refused a license or certification by any other licensing or certifying body and if so, the circumstances of the incident?	____	____
2. Have you ever been or have reason to believe that you are, or will soon be, the subject of any kind of disciplinary investigation or action by any hospital, healthcare organization or licensing or certifying body and if so, the nature of the allegations and the subsequent disposition of the action?	____	____
3. Have you ever been convicted of a felony or misdemeanor, and, if so, the name of the court, the details of the offense, the date of conviction and the sentence imposed?	____	____
4. Have you ever been treated for drug or alcohol abuse, or been hospitalized for any mental illness within the year preceding the filing of the application, or have you ever had such treatment or hospitalization for a condition which affected your ability to perform the functions of a physician assistant?	____	____

AFFIDAVIT OF APPLICANT

State of _____

County of _____

_____of_____
(Applicant) (Address)

being duly sworn says that (s)he is the person referred to in the above application for certification (and photograph below) as a Physician Assistant in the state of New Hampshire; that (s)he is a graduate of an approved program for Physician Assistants; and that all statements herein or attached hereto are each and all true in every respect. Further, (s)he has never been an inmate in an institution for the treatment of insanity, drug addiction or inebriety.

_____
(SIGNATURE OF APPLICANT)

(PHOTO)

Sworn to before me this _____ day of _____, 19___.

(SEAL) _____
(NOTARY PUBLIC)
MY COMMISSION EXPIRES:_____

****

APPLICATION RECEIVED:_____FEE:_____

PERSONAL INTERVIEW BY:_____DATE:_____

CERTIFICATION #:_____ISSUED:_____

Licensure Verification Form

New Hampshire Board of Medicine

RELEASE OF INFORMATION FROM OTHER LICENSING AUTHORITIES

I am applying for a license to practice as a physician assistant in the State of New Hampshire. The NH Board of Medicine requires that the following form be completed by each jurisdiction in which I am now or was previously licensed. This constitutes your authority to release any and all information in your files, favorable or otherwise, directly to the NH Board of Medicine. Kindly mail your response to:

BOARD OF MEDICINE
2 INDUSTRIAL PARK DRIVE, SUITE 8
CONCORD, NEW HAMPSHIRE 03301-8520
Tel: (603) 271-1203

Biographic Information:

_____, P.A.
Last Name First Name Middle Name

_____
Mailing Address City State Zip Code

_____ _____
Social Security Number: Date of Birth:

_____ _____
License Number (if known) Signature

The following should be completed by the licensing authority and returned directly to the NH Board at the address above.

1. Name of Licensing Authority: _____
2. Full Name of Licensee: _____
3. License Number: _____
4. Is License Current? Yes No Expiration Date:_____
5. Is License Restricted? Yes No
6. Previous Disciplinary Action? Yes No
7. Pending Investigations? Yes No

If the answer is yes to questions 5, 6 or 7, please attach supporting information.

Please affix official Board seal here

_____
Signature/Title

_____
Date

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_____PLEASE INDICATE WITH "X"
IF THIS FORM DESIGNATES A
CHANGE IN SUPERVISOR

In accordance with RSA 328-D and regulations issued thereunder, I certify that

_____, P.A. assists me professionally and that I assume responsibility for supervision of his/her professional activities.

_____	_____
RSP Signature	ARSP Signature
_____	_____
(Print or type name)	(Print or type name)
_____	_____
(Professional Address)	(Professional Address)
_____	_____
_____	_____
(NH License Number)	(NH License Number)
_____	_____
(Effective Date of Supervision)	(Effective Date of Supervision)

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PHYSICIAN ASSISTANT ADVISORY COMMITTEE

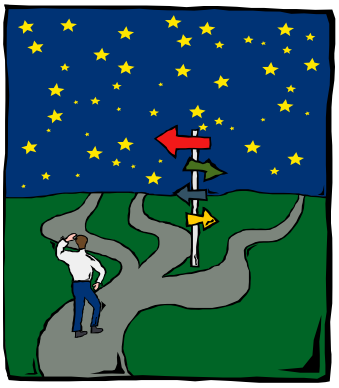
Mark Sullivan, PA
Catholic Medical Center
100 McGregor St
Manchester NH 03102
(603) 663-6340

Patricia L. Niemann, PA
Cardiac Associates of NH
246 Pleasant St., Memorial Bldg, Suite 103
Concord, NH 03301
(603) 224-6070

Robert F. Dunton, M.D.
Cardiac Associates of NH
246 Pleasant Street
Memorial Building, Suite 103
Concord, NH 03301
(603) 224-6070

Robert J. Zahn, M.D.
Pittsfield Medical Center
44 Loudon Road
Pittsfield, NH 03263
(603) 435-8336

Please call one of the above for a personal interview. Thank you.



IMPORTANT NOTICE
FROM
NEW HAMPSHIRE BOARD OF PHARMACY

Pursuant to Med 612.01 (a) "*Any physician assistant requesting the authority to issue prescriptions for legend drugs shall successfully complete the jurisprudence examination administered by the Board of Pharmacy.*"

In order to sit for this examination, you must be **fully licensed** by the Board. A "Temporary" license does NOT meet the requirement.

It is suggested that you forward a **written request**[1] to the address below, requesting the study material package for the PA-C drug law examination. This request **must** be accompanied by a check for **$50.00**, which covers the cost of the study materials and administration of the examination.

New Hampshire Board of Pharmacy
57 Regional Drive
Concord, NH 03301 **(603) 271-2350**

Once the material has been received, please contact the Board of Pharmacy, Compliance Investigations for study guidelines. Once you are comfortable with the material, again, call the Board of Pharmacy in order to establish an appointment for administration of the examination.

Please remember that until such time as this examination has been completed, prescriptive authority has **NOT** been granted.

[1] The study materials will **NOT** be sent pursuant to an oral request.